



TENNESSEE DEPARTMENT OF HEALTH
Health Statistics
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**JOINT ANNUAL REPORT OF HOME HEALTH AGENCIES
2016**

Schedule A – Identification

Schedule B – Organization Structure

Schedule C – Licensure, Accreditations & Memberships

Schedule D – Finances

Schedule E – Utilization

Schedule F – Personnel

Schedule G – Branch Offices

Schedule A – Identification				
<p>According to the Department of Health rules and regulations section 1200-8-26-.11, “a yearly statistical report, the ‘Joint Annual Report of Home Care Organizations,’ shall be submitted to the Department.” Report data for the year specified above. Please read all information carefully before completing your Joint Annual Report. Please complete all items on the Joint Annual Report. Use 0 (zero) when appropriate. Check all computations, especially where a total is required. Please check all checkboxes. Any items which appear to be inconsistent will be queried. Agencies will be reported to the Board for Licensing Health Care Facilities for both failure to file forms and failure to respond to queries. Comments relating to unique aspects of your agency may be submitted with the Report.</p>				
Agency	State ID			
	Legal Name			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did the agency’s name change during the reporting period?		
	If Yes, Prior Name			
	Street			
	City	County		
	State	Zip		
	Area Code	Phone		
Preparer	Name			
	Title			
	Phone Number			
	Email Address			
Administration	Name of Administrator			
	Name of Medical Director			
Reporting Period	Is the reporting period July 1 through June 30 of the year specified above?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If unable to report based on above dates, provide beginning and ending dates (used for all utilization and financial data):	Beginning (mm/dd/yyyy)		
		Ending (mm/dd/yyyy)		
Schedule B – Organization Structure				
Owner	Type	<p>The type of legal entity, except proprietorship, general partnerships and government entities, can be confirmed by entering the legal entity’s name into a search at the Secretary of State web site: http://www.tennesseeanytime.org/soscorp/.</p>		

Schedule A – Identification
Schedule B – Organization Structure

Owner (cont.)	Type (cont.) (Check one type and one sub-type)	<input type="checkbox"/> For-Profit	<input type="checkbox"/> Proprietorship - a business owned by one person.					
			<input type="checkbox"/> General Partnership - an association of two or more persons to carry on as co-owners of a business or other undertaking for profit formed under TCA § 61-1-202, predecessor law, or comparable law of another jurisdiction.					
			<input type="checkbox"/> Limited Partnership (LP) - a partnership formed by two or more persons under the laws of the state of Tennessee, and having one or more general partners and one or more limited partners. TCA Title 61 Chapter 2.					
			<input type="checkbox"/> Limited Liability Partnership (LLP) - governed by TCA § 61-1-106 (c). The law of this state governs relations among the partners and between the partners and the partnership and the liability of partners for an obligation of a limited liability partnership that has filed an application as a limited liability partnership in this state.					
			<input type="checkbox"/> Limited Liability Company (LLC) - established by the "The Tennessee Limited Liability Company Act" found in the TCA § 48-201-101 through § 48-248-606.					
			<input type="checkbox"/> Corporation - defined by the "Tennessee Business Corporation Act" codified in TCA Title 48 Chapters 11-27.					
		<input type="checkbox"/> Non profit	<input type="checkbox"/> Non-Religious Corporation or Association - defined by the "Tennessee Nonprofit Corporation Act" codified in TCA Title 48 Chapters 51-68.					
			<input type="checkbox"/> Religious Corporation or Association - either a corporation or association that is organized and operated primarily or exclusively for religious purposes. Most of the provisions of the Tennessee Nonprofit Corporation Act apply to a religious corporation. Exceptions are specified in TCA § 48-67-102.					
			<input type="checkbox"/> Limited Liability Company (LLC) - a company that is disregarded as an entity for federal income tax purposes, and whose sole member is a nonprofit corporation, foreign or domestic, incorporated under or subject to the provisions of the Tennessee Nonprofit Corporation Act and who is exempt from franchise and excise tax as not-for-profit as defined in TCA § 67-4-1004(15).					
		<input type="checkbox"/> Govern-ment	<input type="checkbox"/> City					
			<input type="checkbox"/> County					
			<input type="checkbox"/> State					
			<input type="checkbox"/> Federal					
			<input type="checkbox"/> Other Government (specify) _____					
		Name of Legal Entity _____						
		Street _____						
		City _____						
		State _____ Zip _____						
		List name(s) and address(es) of individual owner, partners, directors of the corporation, or head of the governmental entity:						
		Name		Address		City	State	Zip
		1.						
		2.						
		3.						
		4.						
		Race of Owner	If owned by an individual		<input type="checkbox"/> White		<input type="checkbox"/> Black	
If owned by corporation or partnership, give race of members			Race		Number			
			White					
			Black					
			Other					

Structure	Check one of the following types of organizations and specify the name of the parent facility where applicable. A hospital based organization is a department of a hospital. A hospital affiliated organization is typically owned or leased by a hospital; not a department of the hospital.	
	Type	
	<input type="checkbox"/>	Free Standing
	<input type="checkbox"/>	Hospital Affiliated
	<input type="checkbox"/>	Hospital Based
	<input type="checkbox"/>	Nursing Home Based
	<input type="checkbox"/>	Public Health Department
	<input type="checkbox"/>	Rural Health Clinic Based

Schedule C – Licensure, Accreditations, Memberships, and Participations

On the following items, please report the status of your agency as of June 30.

Licensure	License Number		
	Most recent survey date (yyyy)		
Accreditation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Commission on Accreditation of Healthcare Organizations	Approval Date (yyyy)
			Expiration Date (yyyy)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Community Health Accreditation Program (CHAP)	Approval Date (yyyy)
			Expiration Date (yyyy)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (specify)	Approval Date (yyyy)
			Expiration Date (yyyy)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (specify)	Approval Date (yyyy)
			Expiration Date (yyyy)
Memberships	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tennessee Association for Home Care	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	THA Home Care Alliance	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (specify)	
Participations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	TennCare	
		If yes, indicate the MCOs with whom you have contracts.	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	AmeriChoiceEast (John Deere)	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	AmeriChoice (Middle)	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	AmeriGroup	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	BlueCare	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	TLC Family Care Healthplan	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	UAHC (OmniCare Health)	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	PHP TennCare	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	TennCare Select	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unison Health Plan	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Windsor Health Plan of TN	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (specify one)	
		If yes, indicate the BHOs with whom you have contracts.	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	TBH	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Premier		

Schedule D – Finances

Gross Revenue by Revenue Source	<p>Enter the amount of gross revenue (your total charges) that your organization received from each of the sources listed during the reporting period. Please note: this reporting period should be consistent with the reporting period listed in Schedule A of this report.</p> <p>TennCare - Tennessee's Medicaid program that is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources.¹</p> <p>Medicare - the federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).¹</p> <p>Medicare HMO – a Health Management Organization (HMO) that has contracted with the federal government under the Medicare+ Choice program to provide health benefits to persons eligible for Medicare that choose to enroll in the HMO, instead of receiving their benefits and care through the traditional fee for service Medicare program.²</p>
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Schedule B – Organizational Structure

Schedule C – Licensure, Accreditations, Memberships, and Participations

Schedule D - Finances

Gross Revenue by Revenue Source (cont.)	Private Pay – payment coming from consumers.				
	Commercial – payment coming from all insurance companies, including BlueCross.				
	TRICARE - the health care program for active duty members of the military, military retirees, and their eligible dependents. TRICARE was called CHAMPUS in the past. ¹				
	Home and Community Based Waiver Programs – the Medicaid program alternative to providing long-term care in institutional settings. ³				
	Other Pay Source - payment coming from sources not included in this specific list of sources.				
	Payment Source		Gross Revenue	Percentage of Total	
	TennCare				
	Medicare				
	Medicare HMO				
	Private Pay				
Commercial					
TRICARE					
Home and Community Based Waiver Programs					
Other Pay Source (specify):					
Total					
Charity Care	Charity Care (Report as a positive number.) Do not include other adjustments to gross revenue such as contractual allowances (e.g. discounts) or bad debt (e.g. not receiving expected payments).				
	Charity Care – services provided to medically needy persons for which the agency does not expect payment. These persons have insufficient income and/or assets with which to pay for their care. "Insufficient income" is defined as an amount not to exceed one hundred percent (100%) of the federal poverty guidelines. They are not eligible for Medicaid or other state or federal programs, or benefits of these programs have been exhausted. The patient has no insurance or has a very limited insurance policy.				
Average Charges by Discipline	Provide actual cost per visit for Medicare Certified and/or charge per visit or charge per hour for Private Duty for the end of your cost reporting year for the following disciplines. For Medicare Certified Home Care Organizations, indicate the average cost per visit from your cost report for each of the disciplines listed as well as Medicare reimbursement. For Private Duty Company, provide the amount your organization charges per visit <u>OR</u> per hour for the services listed.				
	Discipline	Medicare Certified Home Care Organization		Private Duty Company	
		Cost Per Visit	Reimbursement Per Visit	Average Charge Per Visit	Average Charge Per Hour
	Home Health Aide Services				
	Homemaker Services				
	Medical Social Services				
	Occupational Therapy				
	Physical Therapy				
	Skilled Nursing Care				
	Speech Therapy				
	Other (specify):				
Schedule E – Utilization					
Discharges	List the number of discharges by reason during the 12 month reporting period. Total Discharges by Number of Days (Length of Stay) should be calculated from date of admission to date of discharge.				
	Reason for Discharge			Total Number Discharged	
	Physician order (Unplanned)				
	No further care needed; reached maximum functional potential (Goals met)				
	Death				
	Patient request				

Discharges (cont.)	Reason for Discharge		Total # Discharged
	Transfer to hospital from home health agency		
	Transfer to nursing home from home health agency		
	Transfer out of service area		
	Transfer to hospice services from home health agency		
	Patient no longer met payor's home care qualifications for eligibility/ coverage criteria		
	Other (specify):		
	Unknown		
	Total Discharges		
Total Discharges by Number of Days (Length of Stay)			
Patients Served	Category		Number
	Unduplicated	Unduplicated patient census on the first day of the current reporting period	
	Gender (entire reporting period)	Male	
		Female	
		Total (should match race/ethnicity total and patient origin total)	
	Race/Ethnicity (entire reporting period)	The following race/ethnicity definitions were taken from the "OASIS Implementation Manual" of the Centers on Medicare and Medicaid Services, December 2002: American Indian or Alaska Native refers to "a person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment." Asian refers to "a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam." Black or African American refers to "a person having origins in any of the black racial groups of Africa. Terms such as 'Haitian' or 'Negro' can be used in addition to 'Black or African American.'" Hispanic or Latino refers to "a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, 'Spanish origin,' can be used in addition to 'Hispanic or Latino.'" Native Hawaiian or Other Pacific Islander refers to "a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands." White refers to "a person having origins in any of the original peoples of Europe, the Middle East, or North Africa."	
		Race/Ethnicity	Number
		American Indian or Alaska Native	
		Asian	
		Black or African-American	
		Hispanic or Latino	
		Native Hawaiian or Pacific Islander	
		White	
		Multi-Race/Ethnicity (or Other)	
		Unknown	
		Total	
	Revenue Source	Please specify the total number of patients served who received the services below and the number of visits/hours provided to those patients by revenue source. For Medicare Certified Home Care Organizations, report the number of visits. For Private Duty companies, report the number of hours.	

Patients Served (cont.)	Revenue Source (cont.)	Discipline	TennCare		
			Patients	Visits	Hours
		Home Health Aide Services			
		Homemaker Services			
		Medical Social Services			
		Occupational Therapy			
		Physical Therapy			
		Skilled Nursing Care			
		Speech Therapy			
		Other			
		Total			
		Discipline	Medicare		
			Patients	Visits	Hours
		Home Health Aide Services			
		Homemaker Services			
		Medical Social Services			
		Occupational Therapy			
		Physical Therapy			
		Skilled Nursing Care			
		Speech Therapy			
		Other			
		Total			
		Discipline	Medicare HMO		
			Patients	Visits	Hours
		Home Health Aide Services			
		Homemaker Services			
		Medical Social Services			
		Occupational Therapy			
		Physical Therapy			
		Skilled Nursing Care			
		Speech Therapy			
		Other			
		Total			
		Discipline	Private Pay		
			Patients	Visits	Hours
		Home Health Aide Services			
		Homemaker Services			
		Medical Social Services			
		Occupational Therapy			
		Physical Therapy			
		Skilled Nursing Care			
		Speech Therapy			
		Other			
		Total			
		Discipline	Commercial		
			Patients	Visits	Hours
		Home Health Aide Services			
		Homemaker Services			
		Medical Social Services			

Patients Served (cont.)	Revenue Source (cont.)	Discipline	Commercial (cont.)		
			Patients	Visits	Hours
		Occupational Therapy			
		Physical Therapy			
		Skilled Nursing Care			
		Speech Therapy			
		Other			
		Total			
		Discipline	TRICARE		
			Patients	Visits	Hours
		Home Health Aide Services			
		Homemaker Services			
		Medical Social Services			
		Occupational Therapy			
		Physical Therapy			
		Skilled Nursing Care			
		Speech Therapy			
		Other			
		Total			
		Discipline	Home and Community Based Waiver Programs		
			Patients	Visits	Hours
		Home Health Aide Services			
		Homemaker Services			
		Medical Social Services			
		Occupational Therapy			
		Physical Therapy			
		Skilled Nursing Care			
		Speech Therapy			
		Other			
		Total			
		Discipline	Other Pay Source		
			Patients	Visits	Hours
		Home Health Aide Services			
		Homemaker Services			
		Medical Social Services			
		Occupational Therapy			
		Physical Therapy			
		Skilled Nursing Care			
		Speech Therapy			
		Other			
		Total			
		Discipline	Charity Care		
			Patients	Visits	Hours
		Home Health Aide Services			
		Homemaker Services			
		Medical Social Services			
		Occupational Therapy			
		Physical Therapy			
		Skilled Nursing Care			
		Speech Therapy			
		Other			
		Total			

Patients Served (cont.)	Revenue Source (cont.)	Discipline	Total All Revenue Sources		
			Patients	Visits	Hours
		Home Health Aide Services			
		Homemaker Services			
		Medical Social Services			
		Occupational Therapy			
		Physical Therapy			
		Skilled Nursing Care			
		Speech Therapy			
		Other			
		Grand Total			

Patient Origin	List total patients served by age (0-17 years, 18-64 years, 65-74 years, 75+ years and total) and by race (B=Black, W=White, O=Other, including American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander). First , check the box beside each county this home health agency is licensed to operate in regardless of whether any residents from that county received services. Second , indicate by resident county the number of patients who received home health services.								
	Check the counties your agency is licensed to serve.	Number of Patients Served							
		Age (in years)				Total	Race		
		0-17	18-64	65-74	75 +	White	Black	Other	
	<input type="checkbox"/> 1 Anderson								
	<input type="checkbox"/> 2 Bedford								
	<input type="checkbox"/> 3 Benton								
	<input type="checkbox"/> 4 Bledsoe								
	<input type="checkbox"/> 5 Blount								
	<input type="checkbox"/> 6 Bradley								
	<input type="checkbox"/> 7 Campbell								
	<input type="checkbox"/> 8 Cannon								
	<input type="checkbox"/> 9 Carroll								
	<input type="checkbox"/> 10 Carter								
	<input type="checkbox"/> 11 Cheatham								
	<input type="checkbox"/> 12 Chester								
	<input type="checkbox"/> 13 Claiborne								
	<input type="checkbox"/> 14 Clay								
	<input type="checkbox"/> 15 Cocke								
	<input type="checkbox"/> 16 Coffee								
	<input type="checkbox"/> 17 Crockett								
	<input type="checkbox"/> 18 Cumberland								
	<input type="checkbox"/> 19 Davidson								
	<input type="checkbox"/> 20 Decatur								
	<input type="checkbox"/> 21 DeKalb								
	<input type="checkbox"/> 22 Dickson								
	<input type="checkbox"/> 23 Dyer								
	<input type="checkbox"/> 24 Fayette								
	<input type="checkbox"/> 25 Fentress								
	<input type="checkbox"/> 26 Franklin								
	<input type="checkbox"/> 27 Gibson								
	<input type="checkbox"/> 28 Giles								
	<input type="checkbox"/> 29 Grainger								
	<input type="checkbox"/> 30 Greene								
	<input type="checkbox"/> 31 Grundy								
	<input type="checkbox"/> 32 Hamblen								
	<input type="checkbox"/> 33 Hamilton								
	<input type="checkbox"/> 34 Hancock								

Patient Origin (cont.)	Check the counties your agency is licensed to serve.	Number of Patients Served							
		Age (in years)				Total	Race		
		0-17	18-64	65-74	75 +	White	Black	Other	
<input type="checkbox"/> 35 Hardeman									
<input type="checkbox"/> 36 Hardin									
<input type="checkbox"/> 37 Hawkins									
<input type="checkbox"/> 38 Haywood									
<input type="checkbox"/> 39 Henderson									
<input type="checkbox"/> 40 Henry									
<input type="checkbox"/> 41 Hickman									
<input type="checkbox"/> 42 Houston									
<input type="checkbox"/> 43 Humphreys									
<input type="checkbox"/> 44 Jackson									
<input type="checkbox"/> 45 Jefferson									
<input type="checkbox"/> 46 Johnson									
<input type="checkbox"/> 47 Knox									
<input type="checkbox"/> 48 Lake									
<input type="checkbox"/> 49 Lauderdale									
<input type="checkbox"/> 50 Lawrence									
<input type="checkbox"/> 51 Lewis									
<input type="checkbox"/> 52 Lincoln									
<input type="checkbox"/> 53 Loudon									
<input type="checkbox"/> 54 McMinn									
<input type="checkbox"/> 55 McNairy									
<input type="checkbox"/> 56 Macon									
<input type="checkbox"/> 57 Madison									
<input type="checkbox"/> 58 Marion									
<input type="checkbox"/> 59 Marshall									
<input type="checkbox"/> 60 Maury									
<input type="checkbox"/> 61 Meigs									
<input type="checkbox"/> 62 Monroe									
<input type="checkbox"/> 63 Montgomery									
<input type="checkbox"/> 64 Moore									
<input type="checkbox"/> 65 Morgan									
<input type="checkbox"/> 66 Obion									
<input type="checkbox"/> 67 Overton									
<input type="checkbox"/> 68 Perry									
<input type="checkbox"/> 69 Pickett									
<input type="checkbox"/> 70 Polk									
<input type="checkbox"/> 71 Putnam									
<input type="checkbox"/> 72 Rhea									
<input type="checkbox"/> 73 Roane									
<input type="checkbox"/> 74 Robertson									
<input type="checkbox"/> 75 Rutherford									
<input type="checkbox"/> 76 Scott									
<input type="checkbox"/> 77 Sequatchie									
<input type="checkbox"/> 78 Sevier									
<input type="checkbox"/> 79 Shelby									
<input type="checkbox"/> 80 Smith									
<input type="checkbox"/> 81 Stewart									
<input type="checkbox"/> 82 Sullivan									
<input type="checkbox"/> 83 Sumner									
<input type="checkbox"/> 84 Tipton									
<input type="checkbox"/> 85 Trousdale									

Patient Origin (cont.)	Check the counties your agency is licensed to serve.	Number of Patients Served							
		Age (in years)				Total	Race		
		0-17	18-64	65-74	75 +		White	Black	Other
	<input type="checkbox"/> 86 Unicoi								
	<input type="checkbox"/> 87 Union								
	<input type="checkbox"/> 88 Van Buren								
	<input type="checkbox"/> 89 Warren								
	<input type="checkbox"/> 90 Washington								
	<input type="checkbox"/> 91 Wayne								
	<input type="checkbox"/> 92 Weakley								
	<input type="checkbox"/> 93 White								
	<input type="checkbox"/> 94 Williamson								
	<input type="checkbox"/> 95 Wilson								
	96 Unknown								
	97 Other States								
	Total								

Schedule F – Personnel

Type of Employee by Service	Please indicate the number of personnel as of 06/30 (or the last day of the reporting period). Do not include a type of employee for which you do not provide that type of service. For example, do not include Physical Therapists unless you provide Physical Therapy services. Record zero where appropriate. Leave the item blank if the value is unknown. Full Time Equivalent (FTE) = Number of Hours worked by part-time employees per week/40 hours per week. For example, three Registered nurses, each working 20 hours a week, the FTE would be (3x20)/40=1.5. For the purposes of this calculation, if your agency reimburses employees per visit rather than per hour worked, one visit equals one hour in FTE.				
	Type	Number of Employees			
		Full-Time	Part-Time in FTE	Contract in FTE	Total in FTE
Office Staff:	Administrator				
	Assistant Administrator				
	Clinical Director/In-office Clinical Staff				
	Office Personnel (Clerical)				
	Financial/Billing Personnel				
	Other Administrative Personnel (Marketing / Community Education, etc.)				
Field Staff:	Registered Nurses				
	Licensed Practical Nurses				
	Certified Nurses Aides				
	Physical Therapy Services				
	Occupational Therapy				
	Speech/Language Pathology Services				
	Medical Social Services				
	Respiratory Therapists				
	Home Health Aides				
	Homemakers				
	Nutritionists/Dieticians				
	Other Health				
	Other Non-Health				
Total (Office and Field Staff)					

Personnel	Please indicate the number of personnel as of June 30 (or the last day of the reporting period):							
	Registered Nurses	Highest Education Level	Number Currently Employed	Number of Budgeted Vacancies	Average Time Required to Recruit Staff	Number Added in the Past 12 Months	Number Eliminated in the Past 12 Months	
							Clinical	Admin
	Registered Nurses	Associate						
		Diploma						
		Bachelors						
		Masters						
		Doctorate						
		Total						
		Advanced Practice Nurses	Category	Number Currently Employed	Number of Budgeted Vacancies	Average Time Required to Recruit Staff	Number Added in the Past 12 Months	Number Eliminated in the Past 12 Months
							Clinical	Admin
	Nurse Practitioner							
	Clinical Nurse Specialist							
	Total							
	Licensed Practical Nurses	Number Currently Employed	Number of Budgeted Vacancies	Average Time Required to Recruit Staff	Number Added in the Past 12 Months	Number Eliminated in the Past 12 Months		
Occupational Therapists								
Physical Therapists								
Speech Therapists								
Occupational Therapist Assistants								
Physical Therapists Assistants								
Employee Benefits	Does your agency offer the following benefits to any of your employees?							
	<input type="checkbox"/> Yes <input type="checkbox"/> No	401K Plan						
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retirement Plan						
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Health Insurance						
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Life Insurance						
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Child Day Care Center for Employees						
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Education						
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Paid Holiday	If Yes, Number of Paid Holidays					
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Paid Vacation						
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (specify) _____						

Schedule G – Branch Offices				
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have branch offices?			
If yes, please provide names and addresses of up to 12 branch offices:				
Name				
Street				
City		State		Zip
County				

Administrator's Declaration	<input type="checkbox"/>	I, the administrator, declare that I have examined this report and to the best of my knowledge and belief, it is true, correct, and complete.		
Date		(mm/dd/yyyy)		

References

¹ Centers for Medicare and Medicaid Services <http://www.cms.hhs.gov/glossary>

² Managed Care On-Line <http://www.medicarehmo.com>

³ Bureau of TennCare, Home and Community Based Services <http://tennessee.gov/tenncare/ltcare/ltc3.htm>